

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05241

05237

1. PLACE OF DEATH a. COUNTY Worcester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Berlin c. LENGTH OF STAY IN lb 2 Yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Berlin Nursing Home				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland f. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Willards d. STREET ADDRESS 22x-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) Eva Mae Cooper		4. DATE OF DEATH April 25, 1962		5. SEX White		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 10, 1877		9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Mitchell Davis				14. MOTHER'S MAIDEN NAME Roena Dennis													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO. 217-36-1482D				17. INFORMANT Harry Cooper				Address Frankford, Del. RD					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic myocarditis 443X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Arteriosclerosis - Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Diabetes mellitus 15 years																INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)																20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 4:45 p.m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 1940 , 19 to day of death , that (I) (we) last saw the deceased alive on 4-25 1962, and that death occurred at 8 A.M. from the causes and on the date stated above.																	
22a. SIGNATURE Frank Lewis								22b. DATE SIGNED				22c. PHYSICIAN'S NAME (Type) Willards Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4/29/62				23c. NAME OF CEMETERY OR CREMATORY Cooper Family				23d. LOCATION (City, town or county) (State) Willards Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley Silhouette, Del.								25a. REC'D BY REGISTRAR APR 30 '62				25b. REGISTRAR'S SIGNATURE Conrad L. Huns					

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Handwritten notes and signatures, including "The National", "The National", and "The National".

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15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Monterey</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> c. LENGTH OF STAY IN b. <u>75 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Monterey</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Viola</u> Middle <u>M.</u> Last <u>Griffin</u> 4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1962</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Dec 9 - 1886</u> 9. AGE (in years last birthday) <u>75</u> IF UNDER 1 YEAR: Months <u>1</u> Days <u>9</u> Hours <u>15</u> Min. <u>00</u> IF UNDER 24 HRS. Hours <u>15</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Iron Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Snow Hill MD</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Jesse W. Messick</u> 14. MOTHER'S MAIDEN NAME <u>Harriet Jackson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>NO</u> (Yes, no or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Mrs. Grace Griffin, Snow Hill, MD</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Essential Hypertension</u> (c) <u>Years</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>4-6</u> , 19 <u>62</u> to <u>4-17</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>4-17</u> , 19 <u>62</u> and that death occurred at <u>7 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>David Rafat</u> 22c. PHYSICIAN'S NAME (Type) <u>David Rafat, M. D.</u> XXXXXXXXXXXXXXXXXXXX		22b. DATE SIGNED <u>4-18-62</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>10 Bay St., Snow Hill, Md.</u>	
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>April 20/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Whatcoat Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Snow Hill MD</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Maye G. Sumner</u> ADDRESS <u>Snow Hill, MD</u> 25a. REC'D BY REGISTRAR <u>APR 19 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

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David ...
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05243		05239	
1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>	
c. LENGTH OF STAY in 1b <u>84 yrs</u>		d. STREET ADDRESS <u>306 W. Martin</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Ernest Martin</u>		4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1962</u>	
5. SEX <u>Male</u> COLOR OR RACE <u>Caucasian</u>		8. DATE OF BIRTH <u>July 13 1877</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (in years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stationery Factory</u>		11. PLACE OF BIRTH (County & State, or foreign country) <u>Snow Hill, md</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Cleland Martin</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>242-10-7648</u>		17. INFORMANT <u>Mrs. Mayle J. Elliott, Chester, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Acute myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>ASHD</u> (c) <u>unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>few hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <u>4-6-1962</u> to <u>4-6-1962</u> , that (I) (we) last saw the deceased alive on <u>4-6-1962</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>David Rafat</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>4-9-62</u> 22c. PHYSICIAN'S NAME (Type) <u>DAVID RAFAT</u> 22d. ADDRESS <u>Snow Hill MD</u> 23a. BURIAL, CREMATION, or REBURYAL (Specify) <u>Buried April 9/62 Ebenezer Cemetery</u> 23b. DATE THEREOF <u>4-9-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Snow Hill, md</u> 23d. LOCATION (City, town or county) (State) 24. FUNERAL DIRECTOR'S SIGNATURE <u>May E. Dennis, Snow Hill, md</u> ADDRESS <u>Snow Hill, md</u> 25a. REC'D BY REGISTRAR DATE <u>APR 11 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

(M)

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05240

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

05244

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stockton</u>		c. LENGTH OF STAY IN 1b <u>83 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stockton</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elmer</u> Middle <u>P.</u> Last <u>Parsons</u>				4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1962</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 28, 1878</u>		9. AGE (In years last birthday) <u>83 5/19</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>19</u>	IF UNDER 24 HRS. Hours <u>19</u> Min. <u>19</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Local</u>		11. BIRTHPLACE (State or foreign country) <u>Stockton, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Jehu Parsons</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Miss Maude E. Parsons, Stockton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>776X</u> IMMEDIATE CAUSE (a) <u>Gunshot Wound in the Abdomen</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mental depression</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Robert C. La Mar</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> 4-18-62 DATE SIGNED			
EXAMINER'S NAME (Type) <u>Robert C. La Mar, M.D., 104 Bay St., Snow Hill, Md.</u>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 20/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Portersville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Stockton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman A. Klemm, Snow Hill, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 18 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Clifford L. Thomas</u>	

MEDICAL CERTIFICATION

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FOR STATE
DEATH CERTIFICATE

1944

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE

1944

NAME OF DECEASED <i>Robert L. Smith</i>		DATE OF DEATH <i>10-15-44</i>
AGE <i>35</i>		SEX <i>Male</i>
RACE <i>White</i>		EDUCATION <i>High School</i>
OCCUPATION <i>Engineer</i>		RESIDENCE <i>1234 Main St.</i>
PLACE OF DEATH <i>Home</i>		CAUSE OF DEATH <i>Heart Disease</i>
MANNER OF DEATH <i>Natural</i>		IMMEDIATE CAUSE OF DEATH <i>Myocardial Infarction</i>
DISEASE OR INJURY <i>Coronary Artery Disease</i>		PERMANENT CAUSE OF DEATH <i>Coronary Artery Disease</i>
SIGNATURE OF MEDICAL EXAMINER <i>Dr. J. H. Jones</i>		DATE <i>10-15-44</i>
SIGNATURE OF DECEASED <i>Robert L. Smith</i>		DATE <i>10-15-44</i>
SIGNATURE OF WITNESS <i>John Doe</i>		DATE <i>10-15-44</i>
SIGNATURE OF SECOND WITNESS <i>Jane Smith</i>		DATE <i>10-15-44</i>
SIGNATURE OF THIRD WITNESS <i>John Doe</i>		DATE <i>10-15-44</i>
SIGNATURE OF FOURTH WITNESS <i>Jane Smith</i>		DATE <i>10-15-44</i>
SIGNATURE OF FIFTH WITNESS <i>John Doe</i>		DATE <i>10-15-44</i>
SIGNATURE OF SIXTH WITNESS <i>Jane Smith</i>		DATE <i>10-15-44</i>
SIGNATURE OF SEVENTH WITNESS <i>John Doe</i>		DATE <i>10-15-44</i>
SIGNATURE OF EIGHTH WITNESS <i>Jane Smith</i>		DATE <i>10-15-44</i>
SIGNATURE OF NINTH WITNESS <i>John Doe</i>		DATE <i>10-15-44</i>
SIGNATURE OF TENTH WITNESS <i>Jane Smith</i>		DATE <i>10-15-44</i>

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15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> c. LENGTH OF STAY IN 1b <u>88 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> d. STREET ADDRESS <u>216 E. Martin</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>E</u> Last <u>Richardson</u>		4. DATE OF DEATH Month <u>April</u> Day <u>30</u> Year <u>1962</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 6 - 1873</u>	
9. AGE (In years last birthday) <u>88 4/24</u>		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>24</u> Hours <u>0</u> Min. <u>0</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Shoe Store</u>	
13. FATHER'S NAME <u>Thomas H. Richardson</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Bowen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs Margaret H. Richardson</u>		18. ADDRESS <u>Snow Hill, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CORONARY OCCLUSION</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO SCLEROSIS</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH MINUTES <u>15 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NON FATAL CORONARY OCCLUSION 1956</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> 19 <u>56</u> to <u>April 30</u> 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>April 26</u> 19 <u>62</u> , and that death occurred at <u>3:30 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert C. Lamar</u> M.D.		22b. DATE SIGNED <u>4/30/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert C. Lamar</u>		22d. ADDRESS <u>104 BAY ST. SNOW HILL, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>May 2/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Shelton Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Snow Hill, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>May 6. Dennis</u>		25a. REC'D BY REGISTRAR <u>DATE MAY 3 '62</u>	
ADDRESS <u>Snow Hill, Md</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05246		05242	
1. PLACE OF DEATH a. COUNTY <u>Worcester</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Shridette</u> c. LENGTH OF STAY IN 1b <u>72 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Shridette</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. MARITAL STATUS DECEASED (Type of person) 5. SEX <u>male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Jan 31 1890</u> 9. AGE (in years last birthday) <u>72 yrs.</u> IF UNDER 1 YEAR Months Days Hours Min. 10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>Retired Farmer own Farm</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Shridette, md</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Shridette, md</u> 12. CITIZEN OF WHAT COUNTRY? <u>md</u>			
13. FATHER'S NAME <u>James Riley</u> 14. MOTHER'S MAIDEN NAME <u>Mary Stanford</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> 16. SOCIAL SECURITY NO. <u>219-14-3538</u> 17. INFORMANT <u>Mrs Annie A. Riley, Shridette, md</u> 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Acute Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>A.S.H.D</u> INTERVAL BETWEEN ONSET AND DEATH <u>few hours</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>years</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>4-8</u> 19 <u>62</u> to <u>4-8</u> 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>4-8</u> 19 <u>62</u> and that death occurred at <u>3 PM</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>David Rafat</u> 22c. PHYSICIAN'S NAME (Type) <u>DAVID RAFAT</u>		22b. DATE SIGNED <u>49-62</u> 22d. ADDRESS <u>Snow Hill, Md.</u>	
23a. BURIAL, CREMATION, DATE THEREOF <u>April 11/62</u> 23b. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery Shridette, md</u> 23c. LOCATION (City, town or county) (State)		24. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne E. Harris</u> 25. REC'D BY REGISTRAR <u>APR 11 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

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Chickadee

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W. H. H. H.

Chickadee

Oct 8 1890

Jan 31 1891

Chickadee

Chickadee

Chickadee

My dear Mr. H. H. H. H.

I am very glad to hear from you.

I am very glad to hear from you.

I am very glad to hear from you.

I am very glad to hear from you.

I am very glad to hear from you.

I am very glad to hear from you.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05247

05243

1. PLACE OF DEATH a. COUNTY WORCESTER b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL BERLIN c. LENGTH OF STAY IN 1b 71 yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY WORCESTER c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL BERLIN d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARGIE Middle ANNA Last Taylor		4. DATE OF DEATH Month APRIL Day 29 Year 1962			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 25 1890	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months 71 Days 71 Hours 71 Min. 71
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) NEWARK, MD.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Richard Harmon		14. MOTHER'S MAIDEN NAME Anna Richardson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 221-01-4013		17. INFORMANT FARRELL Taylor Address BERLIN Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion acute 420.1 DUE TO Myocardial failure severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO AS Cardiovascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diverterculitis acute					
INTERVAL BETWEEN ONSET AND DEATH Instant 59 years 59 years					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from April 29, 1962 to April 29, 1962 , that (I) (we) last saw the deceased alive on April 29, 1962 , and that death occurred at 138 M, from the causes and on the date stated above.					
22a. SIGNATURE Francis J. Townsend Jr		M.D. Francis J. Townsend Jr		22b. DATE SIGNED April 1, 62	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Clean City, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		MAY 1, 1962		EVERGREEN	
23d. LOCATION (City, town or county) (State)		BERLIN Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Anna A. Burbage		ADDRESS Berlin, Md.		25a. REC'D BY REGISTRAR MAY 3 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Thomas					

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Rural Bldg. 1100
Maryland
Burlington

MIRREIE Anna Taylor
June 22 1890
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NEWARK, N.J. 112 H
Richard Harmon
Anna Richardson

25 of 1012 Farrell Taylor
Burlington N.J.

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Evergreen
Burlington

TO HEALTH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishop		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishop	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) EE		d. STREET ADDRESS 1 RFD	
3. NAME OF DECEASED (Type or print) Dewey Franklin Tingle		4. DATE OF DEATH April 27, 1962 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 24, 1898
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George P. Tingle		14. MOTHER'S MAIDEN NAME Anna M. Campbell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Gal Cropper Bishop, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocarditis. 4-22 DUE TO (b) Chronic Myocarditis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-26 to 4-27, 1962, that (I) (we) last saw the deceased alive on 4-26, 1962, and that death occurred at 2 PM, from the causes and on the date stated above.		22a. SIGNATURE Clifford E. Schott M.D.	
22b. DATE SIGNED		22c. ADDRESS 426 644-27 123	
22d. ADDRESS 22b. DATE SIGNED		22e. ADDRESS 22b. DATE SIGNED	
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05249

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05245

Item 1 Film G312 5/3/62 iwl

1. PLACE OF DEATH a. COUNTY <i>Worcester</i>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>WOR</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ocean City</i>		c. LENGTH OF STAY IN lb <i>DOA</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>on scene of death-</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>FRANKLIN William Tubbs</i>		4. DATE OF DEATH Month Day Year <i>APRIL 26 1962</i>	
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 8, 1910</i>	
9. AGE (In years last birthday) <i>51</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>WATERMAN</i>		12. KIND OF BUSINESS OR INDUSTRY <i>Seafood</i>	
13. BIRTHPLACE (State or foreign country) <i>Bishopville MD</i>		14. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. FATHER'S NAME <i>William Tubbs</i>		16. MOTHER'S MAIDEN NAME <i>Minnie SAUAGE</i>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <i>No</i>		18. SOCIAL SECURITY NO. <i>218-10-1266</i>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4-20 CORONARY Occlusion Acute</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>A.S. Coronary artery disease</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i> <i>44 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
22a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		22b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
22c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22d. (City or town) (County) (State)	
23. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, town, or county) <i>Ocean City, MD April 26, 1962</i>	
ACTUAL SIGNATURE <i>Francis J. Townsend Jr</i> EXAMINER'S NAME (Type) <i>FRANCIS J. Townsend JR</i>		DATE SIGNED <i>April 26, 1962</i>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24b. DATE THEREOF <i>April 29, 1962</i>	
24c. NAME OF CEMETERY OR CREMATORY <i>ST. MARTINS</i>		24d. LOCATION (City, town, or country) (State) <i>Bishopville Maryland</i>	
25. FUNERAL DIRECTOR <i>Anna A. Bullock Berlin MD</i>		26. REC'D BY REGISTRAR <i>MAY 1 '62</i>	
27. REGISTRAR'S SIGNATURE <i>Arthur E. Knapp</i>			

1922

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CERTIFICATE OF DEATH

Reg. Dist. No. 05248

05252

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bishop</u>		c. LENGTH OF STAY IN 1b <u>?</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bishopville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Rural Box 273</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Wooden</u> Last <u>Wooden</u>				4. DATE OF DEATH Month <u>Apr.</u> Day <u>21</u> Year <u>1962</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10, 1901</u>	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months <u>21</u> Days <u>21</u>		IF UNDER 24 HRS. Hours <u>21</u> Min. <u>19</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Portsmouth, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Rhubin Jackson</u>			14. MOTHER'S MAIDEN NAME <u>Julia Hunt</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Augustus Wooden</u> Address <u>Bishop, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>443</u> X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive C-v Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>4 wks</u> <u>8 yrs</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5/14</u> , 19 <u>54</u> , to <u>4/19</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>4-19</u> , 19 <u>62</u> , and that death occurred at <u>7:00 A</u> .M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Irving U. Sully, Jr.</u> M.D.			ADDRESS (Street, city or town, state) <u>Berlin Md</u>				
PHYSICIAN'S NAME (Type) <u>Irving U. Sully, Jr. M.D.</u>			DATE SIGNED <u>4/24/62</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/24/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Portsmouth Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry N. Watson</u>				ADDRESS <u>Pocomoke City, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 26 '62</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Travis</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1952

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>	
SEX <i>Male</i>		RACE <i>White</i>	
DATE OF BIRTH <i>Jan 15 1907</i>		PLACE OF BIRTH <i>St. Louis, Mo.</i>	
DATE OF DEATH <i>Dec 10 1952</i>		PLACE OF DEATH <i>St. Louis, Mo.</i>	
CAUSE OF DEATH <i>Myocardial Infarction</i>		MANNER OF DEATH <i>Natural</i>	
DISEASE OR INJURY <i>Coronary Artery Disease</i>		IMMEDIATE CAUSE <i>Myocardial Infarction</i>	
INTERMEDIATE CAUSE <i>Atherosclerosis</i>		UNDERLYING CAUSE <i>Coronary Artery Disease</i>	
SIGNS AND SYMPTOMS <i>Severe chest pain, sweating, nausea</i>		TREATMENT <i>Aspirin, morphine</i>	
HISTORY <i>Long history of hypertension</i>		FAMILY HISTORY <i>None</i>	
SOCIAL HISTORY <i>Smoker, 20 cigarettes per day</i>		OCCUPATION <i>Engineer</i>	
EDUCATION <i>High School Graduate</i>		RELIGION <i>Catholic</i>	
MARRIAGE <i>Married</i>		CHILDREN <i>2</i>	
PREVIOUS ILLNESSES <i>Hypertension, Diabetes</i>		MEDICATIONS <i>None</i>	
HISTORICAL FACTS <i>None</i>		LABORATORY TESTS <i>None</i>	
X-RAY <i>None</i>		AUTOPSY <i>None</i>	
SIGNATURE OF PHYSICIAN <i>Dr. J. K. Smith</i>		SIGNATURE OF REGISTRAR <i>John Doe</i>	
DATE <i>Dec 10 1952</i>		PLACE <i>St. Louis, Mo.</i>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05250
CERTIFICATE OF DEATH
05246

1. PLACE OF DEATH a. COUNTY WORCESTER b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL NEWARK c. LENGTH OF STAY IN b 61 yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE MARYLAND f. COUNTY WORCESTER c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL NEWARK Md d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Thomas WARREN JR.		4. DATE OF DEATH Month Day Year April 27 1962	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1901
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY Ironshire Md.	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William WARREN		14. MOTHER'S MAIDEN NAME JENNIE GAULT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 217-30-8038		16. SOCIAL SECURITY NO. 217-30-8038	
17. INFORMATION NELDA LEE WARREN NEWARK		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4291 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) operation cervical gland DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4-1-62 to 4-27-62 , that (I) (we) last saw the deceased alive on 4-27-62 , and that death occurred at 7:30 PM , from the causes and on the date stated above.		22a. SIGNATURE Clifford E. Schott M.D. 22b. DATE SIGNED 4-27-62	
22c. PHYSICIAN'S NAME (Type) CLIFFORD E. SCHOTT MD BERLIN, MD.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF April 29, 1962	23c. NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL	23d. LOCATION (City, town or county) (State) BERLIN Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Anna A. Burbage Berlin, Md.		25a. REC'D BY REGISTRAR DATE MAY 1 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hume			

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TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death (page 4 may be retained by the hospital or attending physician). After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Worcester</i> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Urdeltree</i> c. LENGTH OF STAY IN 1b <i>62 yrs</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Worcester</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Urdeltree</i> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Barrie</i> Middle <i>S.</i> Last <i>Webb</i>		4. DATE OF DEATH Month <i>April</i> Day <i>10</i> Year <i>1962</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 27-1888</i>
9. AGE (In years last birthday) <i>73 9/13</i>		10. IF UNDER 1 YEAR Months <i>13</i> Days <i>9</i> Hours <i>13</i> Min.	
11. BIRTHPLACE (County & State, or foreign country) <i>Salisbury, MD</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>William & Dickerson</i>		14. MOTHER'S MAIDEN NAME <i>Arrie Jane Jones</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes give war and dates of service)		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Mr. Harold W. Webb, Urdeltree, MD</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Breast</i> DUE TO <i>Metastatic cancer to liver & Omen tum</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>170X</i> (b) <i>Metastatic cancer to liver &</i> (c) <i>Omen tum</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 1/2</i> <i>14 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
21. I certify that (I) (this hospital) attended the deceased from <i>1958</i> to <i>April 10, 1962</i> that (I) (we) last saw the deceased alive on <i>April 9, 1962</i> and that death occurred at <i>1958</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Paul Cohen</i> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, or other disposal (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Clay & Son</i>		25a. REC'D BY REGISTRAR <i>APR 13 '62</i>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>	

1925

1925

(1)

(1)

The following is a list of the
 names of the persons who
 have been elected to the
 office of the President of the
 United States since 1789.
 The names are given in
 alphabetical order of the
 year in which they were
 elected.

1925

Paul Brown

The following is a list of the
 names of the persons who
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 office of the President of the
 United States since 1789.
 The names are given in
 alphabetical order of the
 year in which they were
 elected.